

First Steps

UTS TRAINING TIMES

Volume 7 Issue 3

August 2011

Inside this issue....

- Last November marked the 35th anniversary of the *Education for All Handicapped Children Act*, Public Law (P.L.) 94-142. This landmark legislation, the precursor to the Individuals with Disabilities Education Act (IDEA) has forever changed the expectations and aspirations of children with disabilities and their families.
- This is the 25th edition of the Training Times. Since the last Index of Articles appeared in 2008, we thought it was time for an update. The index is organized by article topics. Full versions of all previous issues of the Training Times can be found on the UTS website, click on Newsletters.
- Recent changes to the First Steps System have necessitated revisions to some policies. Please review the Policy Review and Legislation Update Q & A. Questions regarding these updates should be directed to state staff at firststepsweb@fssa.in.gov.



Enjoy the summer, snow will be falling before you know it...

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INDIANA'S UNIFIED TRAINING SYSTEM

"Creating Learning Opportunities for Families and Providers Supporting Young Children"

First Steps Enrollment and Credential Training Requirements

Provider Level - New	Training for Enrollment	Training for Initial Credential
Service Coordinator (Intake and Ongoing) New to First Steps December 2007 and after	SC 101—SC Modules (self-study)	SC 102 within 3-6 months of employment date SC 103 within 6-9 months of employment date Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 15 points for initial credential
Direct Service Provider (new to First Steps December 2007 and after)	First Steps Orientation or DSP 101—Provider Orientation Course (self-study)	DSP 102 - 1/2 day within 3-6 months of enrollment (on-site) DSP 103 - 1/2 day within 6-12 months of enrollment (on-site) Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Provider Level - Credentialed	Training for Enrollment	Training for Annual Credential
Service Coordinator (Intake or Ongoing who has completed initial credential)	SC Orientation and Service Coordination Level 1 or SC 101 – SC Modules (self-study)	Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential
Direct Service Provider (who has completed initial credential)	First Steps Orientation (on-site or self-study) or DSP 101 - Provider Orientation Course (self-study)	Quarterly (4) – Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential

Attention: New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the quarterly *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (<http://www.utsprokids.org>) to register for UTS trainings. Obtaining an account is easy.

1. Click the Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click the Update Information.
5. Register for your annual training fee.

6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Janice in the UTS Connect office at: registration@utsprokids.org

Indiana First Steps
UTS Training Times
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Web Address: <http://www.utsprokids.org>

Email: Training questions training@utsprokids.org

Registration questions: registration@utsprokids.org

Service Coordinator Training Dates for 2011

Service Coordination 102: All service coordinators must enroll and complete SC 102 3- 6 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesday	August 16, 2011	ProKids, Inc. Indianapolis	9-4pm
Tuesday	November 8, 2011	ProKids, Inc. Indianapolis	9-4pm

Service Coordination 103: All service coordinators must complete SC103 6-9 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesday	September 20, 2011	ProKids, Inc. Indianapolis	9-4pm
Tuesday	December 13, 2011	ProKids, Inc. Indianapolis	9-4pm

DSP 102 and DSP 103 New Provider Follow Up Orientation

All newly enrolled providers must complete the DSP series 101, 102 and 103 within the first year of their enrollment. DSP 101 is required for provider enrollment. DSP 102 must be completed three to six months following the provider enrollment date and DSP 103 must be completed six to twelve months following the provider enrollment date. Completion dates for these courses must be documented on the Annual Attestation Statement. The training dates for DSP 102 & 103 are listed below. Usually these trainings are held on the first Tuesday of each month at ProKids Inc. Since there are specific timelines for completion of DSP 102 and DSP103, that allow time for experience in the First Steps System, **providers may NOT take both courses on the same day.**

DSP 102 Dates	Time	DSP 103 Dates	Time
September 6, 2011	1:00-4:00PM	September 6, 2011	9:00-12:00PM
October 4, , 2011	1:00-4:00PM	October 4, 2011 9	9:00-12:00PM
November 1, 2011	1:00-4:00PM	November 1, 2011	9:00-12:00PM
December 6, 2011	1:00-4:00PM	December 6, 2011	9:00-12:00PM

AEPS 2-DAY Certification Course

This course provides a 2 day, comprehensive overview of the Assessment, Evaluation and Programming System (AEPS) for Infants and Children. The AEPS is a criterion-referenced developmental assessment tool for children, birth to six years. This course is required for all ED Team members. The 2-day AEPS course may also be used as a First Steps Core Training (FSCT) for your First Steps initial or annual credential. **Cost: \$75**

August 4 & 5, 2011

Additional Opportunities for Credential Points

Providers may utilize trainings (on-site and self-study) and conferences outside of UTS to meet their initial or annual credential points as long as the training is related to provider or service coordinator competencies and it is relevant to infants through age 6. These may include training offered at the SPOE Provider Meetings, association conferences (APTA, ASHA, etc.), hospital based conferences or grand rounds, other local, regional and national conferences, and books, videos and online training. You must keep a copy of the agenda or brochure that includes date, speakers, an agenda/content information and the time spent in the sessions you attended or a one page summary of the self-study training in your credential file. More information on credentialing can be found in the recently revised Personnel Guide at

<http://www.eikids.com/in/matrix/docs/pdfs/First Steps Personnel GuideRevised 12-2010.pdf>



OSERS

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

News, Events and Updates from the Office of the Assistant Secretary

November 29, 2010

Dear Colleagues:

On November 29, 1975, the U.S. Congress enacted the *Education for All Handicapped Children Act*, Public Law (P.L.) 94-142. This landmark law together with subsequent amendments as currently reflected in the *Individuals with Disabilities Education Act (IDEA)*; P.L. 108-446) supports states and localities in protecting the rights of, meeting the individual needs of and improving results for infants, toddlers, children and youths with disabilities and their families.

As we celebrate the 35th anniversary of *IDEA* this year, significant national progress has been made in ensuring the civil rights and providing equal access to education for all children with disabilities. *To honor this anniversary, OSERS and the Department of Education brought together leaders* from the White House, Members of Congress and their staff, education leaders, advocates, educators, academics and government officials to celebrate and reaffirm our support for IDEA and to honor the many and varied contributions of infants, toddlers and youths with disabilities, their parents, teachers, related services personnel and administrators.

Today, I'd like to share my remarks from that celebration, and encourage you to visit OSERS IDEA Web page.

Sincerely,

Alexa Posny, Ph.D.

November 18, 2010
Russell Senate Office Building
Washington, D.C.

Henry David Thoreau once wrote: Things do not change; we change. Every person in this room is part of a civil rights movement that has produced changes once unimaginable. Some of us chose to be a part of this movement. For others, the movement chose us. But all of us have worked to fulfill an indelible truth set forth in a piece of legislation we celebrate today: That every child in this country has a basic right to learn and having a disability does not alter that right.

I began my career in special education before that truth was set down in legislation. I knew at an early age, when my neighborhood playmate who had Down syndrome didn't get on the bus with me on my first day of kindergarten, that something wasn't right. And I, like many others in this room, later began a career dedicated to changing what was possible for students with disabilities.

Joel Barker once said: Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world. We have changed a lot since Nov. 29, 1975. We have transitioned into one of the most diverse societies in a world with far fewer boundaries.

We have developed materials, strategies, and technologies that have changed the way we do almost everything, including educate students with disabilities. For example, we can use technology to measure how well students understand concepts, to translate a teachers voice into Braille, to help students with dyslexia learn to spell and write well, while keeping pace with class content.

In 1975, P.L. 94-142 gave students with disabilities access to public schools. But access was not enough. And so, we changed those rules as well to ensure students with disabilities now are educated to the same high standards as all other students.

Following are a couple of notes that students wrote about one of their classmates, who has a disability.

"The reason it's a good idea for kids like Mikey to be with us is because if all the kids like Mikey were in the same class, they wouldn't get to know many people and we wouldn't get to know anybody like Mikey."

-Jenny

"He needs the same things we do ... food and comfort ... love ... friends ... a cozy bed to sleep in."

-The Class

What we know is this: Students are more alike than different. With effective educational practices, schools can educate well—and together—a wide range of students with better outcomes for all.

Students with disabilities have become more meaningfully included in general education classrooms. Educators, parents, policymakers and peers expect more of students with disabilities than ever before. And these same students, with appropriate supports, not only reach but often exceed the bar set before them.

Last April, Secretary of Education Arne Duncan said: "President Obama and I believe that every child deserves a world-class education. When the president says every child, it is not just rhetoric—he means every child, regardless of his or her skin color, nationality, ethnicity, or ability."

I will add that we know that, given the right supports, every child can thrive. I'd like to highlight a few other things that we know:

- We know that parents are a child's first teacher and that families need to be engaged in a child's learning and schools.
- We know that learning doesn't start when a child starts kindergarten, and so we've invested in Part C programs to identify children who need help reaching developmental goals early on and provide them with appropriate support.
- We know that teaching is the top in-school determinant of student success, and so we continue to recruit, train and retain special education teachers, related services personnel and paraprofessionals who are at the top of their craft.
- We know that adults must be held accountable for helping students reach the bar set before them.
- We know that 80 percent of students with learning disabilities are categorized as having a reading disability, and so we continue to develop reading programs that help all children gain reading proficiency.
- We know that transitions are tough, and so we've paid extra attention on transitioning students with disabilities from early childhood programs to kindergarten, from middle school to high school, and from high school to college and the workforce.
- We know that the lines between the effects of poverty and disability can be blurred, yet, regardless of etiology, we have developed strategies to overcome both.
- We know that technology represents a gateway to learning for many of our children and thus we continue to invest in assistive technology that improves access and achievement for students with disabilities.

This list is familiar to any educator—special or general. Family engagement, early childhood programs, great teaching, high expectations, literacy, accountability, technology: These are key components of learning for all students, including students with disabilities.

Over the past 35 years, we've worked to change a system that helped a select group of students succeed into one that can be molded to meet the nuanced needs of each of our nation's 50 million K–12 students. Like others before it, this change has not been easy. Even within the disability community, we have discussed the merits of different educational tactics. We have questioned where we fit within the bigger picture. But in 2010, at more than 12 percent of the overall student population, students with disabilities are truly a part of—not separate from—the diversity of American public schools. As such, we want to make certain, as Arne pointed out, that the *Elementary and Secondary Education Act (ESEA)* includes children with disabilities and that *Individuals with Disabilities Education Act (IDEA)* programs provide extra supports to help students with disabilities achieve challenging standards. We want to make sure that *ESEA* and *IDEA* programs and other Department initiatives are coordinated, so that, for example, our TEACH.gov initiative, which attracts new talent to teaching especially in high-need areas like special education, and our Part D Personnel Prep programs work together to prepare great teachers and related services personnel through as many channels as possible.

Abraham Lincoln once said: "The best way to predict your future is to create it." We must continue to create the future. As we continue to work toward education goals, we must refine our systems, policies and practices to make certain that we educate all students to the highest possible standard; that we prepare all students for jobs in the 21st century; and that we promote the countless ways in which we are more similar than different, while also recognizing, respecting and addressing our differences. And, in so doing, we will continue along a trajectory of change set into motion nearly 35 years ago. We will continue to change what's possible.

I want to thank each and every one of you for your contributions to these changes. Helen Keller said: "True happiness... is not attained through self-gratification, but through fidelity to a worthy purpose." We can all be truly happy today, for our purpose is worthy and we are faithful in our pursuits of it. Thank you for your dedication, your work and your passion.

Thank you for being here today and for all that you do each day to improve the lives of students with disabilities.



About Early Home Learning Matters

The Family and Parenting Institute is the leading center of expertise on families and parenting in the UK. Families, in all their diversity, form the basis of our society and the foundation for the future. Our mission is to support them in bringing up children.

Our aim is the wellbeing of children and families and to achieve this, we carry out research and policy work to find out what matters to families and parents. We develop ideas to improve the services families use and to improve the environment in which children grow up. We work to inform policy-makers and public debate and we develop practical resources for people working with families.

The Family and Parenting Institute was funded by the DCSF to create this website and the associated handbook. It is now well evidenced that the home learning environment is more influential in determining children's outcomes than ability, family background or material circumstances.

The earliest years (birth to three) of a child's life are the years in which the brain develops most. This development is significantly affected both by a child's relationships with caregivers and the activities and opportunities they have inside and outside the home during these crucial three years.

Early Home Learning Matters focuses on effective ways of helping children achieve their potential, particularly those from disadvantaged backgrounds. It is for anyone working with parents of children from birth to five years of age, or developing early years services – as well as for parents or anyone involved in bringing up children. It brings together key messages from research, practice and parents themselves to provide key information that will help you:

- understand the evidence about brain development and the vital role of parents, both fathers and mothers
- plan effective services to support early learning and development at home
- reach and include vulnerable families to overcome intergenerational cycles of disadvantage
- enable parents to gain the understanding, skills and confidence they need to help their children flourish.



Why work with parents?

The evidence is overwhelming. Parents' involvement in their children's early learning has a huge and lasting impact. We also know that parental involvement is more successfully achieved through a partnership approach to work with parents.

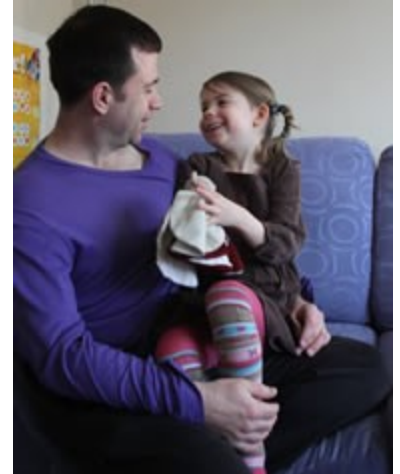
As the Warnock report stated so many years ago in 1978:

"Parents can be effective partners only if professionals take notice of what they say and how they express their needs, and treat their contribution as intrinsically important."

This section will help you put this partnership approach into practice and deliver services that give parents the understanding, skills and confidence to help their children succeed. The earlier you are able to engage parents in their children's learning as part of their daily life at home, the greater the positive impact on children at risk of learning delay and poor outcomes is likely to be.

The pages within this section will help you:

- understand the rationale for involving parents in improving outcomes for children
- make decisions about who you are trying to reach
- think about how you are going to reach and engage parents of children at risk of learning delay
- decide what services will meet the needs of diverse and vulnerable families
- understand what parents need from early years services
- ensure that all families are included.



Improving outcomes

The link between social disadvantage and underachievement is well-established and is compounded for children from minority ethnic backgrounds where English is not the language spoken at home.



Parents are key to improving outcomes for children, particularly those from disadvantaged backgrounds. When parents have the knowledge and skills to play and engage in simple learning activities at home with their children as part of normal daily life, this can help their children overcome risk factors such as poverty and class that are linked to underachievement and a continued cycle of social exclusion.

- How parents relate to their children from the moment of birth and what they do with them during their early years has a major impact on children's later social, emotional and intellectual development. Sylva et al, 2004
- The quality of a child's relationships and learning experiences in the family has more influence on future achievement than innate ability, material circumstances or the quality of pre-school and school provision. Sylva et al, 2004
- It is possible to engage parents from disadvantaged backgrounds in their children's learning. Evangelou et al, 2008
- It is possible to improve the home learning environment. Evangelou et al, 2008

The 2008 DCSF briefing for local authorities *Supporting parents to engage in their child's early learning* highlights why programs and mainstream funding that support parental engagement in their young children's learning and development should be prioritized within local decision making and Children and Young People's Plans.

The research evidence about the importance of a child's early years is highly significant when making strategic decisions about allocation of resources. A child's future is significantly shaped by early relationships, brain development and play-based learning opportunities. The earlier in a child's life that resources to support parenting and parent involvement in learning are focused, the more impact they will have in turning round cycles of disadvantage. (Continued on page 8)

Engaging parents

Reaching and including parents of children at risk of learning delay is a core task in developing and delivering effective services to improve outcomes for children. It can be a time-consuming and challenging task, requiring persistent and creative outreach work. This section will look at what stops parental involvement and help you think about how your service could overcome these barriers.

In their study of what works in parenting support, Moran et al. looked at what helped services in:

- **'getting'** parents (enabling them to use the service in the first place)
- **'keeping'** parents (enabling them to attend sessions regularly or complete a course) and
- **'engaging'** parents (making it possible for them to engage actively in what the service has to offer).

They highlighted the importance of five factors in successfully managing these tasks: relational; practical; cultural and contextual; strategic and structural.

Barriers to parental involvement

"We need to begin with the firm belief that all parents are interested in the development and progress of their own children." Pen Green Centre for Under Fives and Families

Both experience from practice and findings from research suggest that many parents lack knowledge, information, confidence and resources in relation to early home learning and children's development, but not interest or a desire to be involved.

So what are the factors that get in the way and prevent parents getting the support and knowledge they need and that services can provide?



Barriers at the service / practitioner level

- Poor communication and relationship skills on the part of practitioners, such as using jargon, 'talking down' to parents and behaving like the expert.
- Lack of practitioner knowledge about the importance of parental involvement.
- Lack of practitioner confidence and skills to work with parents.
- Services not tailored to parents' needs, level of knowledge or circumstances.
- Practitioner resistance to parental involvement and negative attitudes towards parents.
- Location of settings, unwelcoming venues and inadequate transport.
- Staff unrepresentative of the parents they are trying to reach e.g. low numbers of male role models in the workforce is a barrier to engaging fathers.
- Lack of funding and capacity.

Barriers at the parent level

Experiences and beliefs

- Poor experiences of education or services, leading to negative attitudes and lack of trust on the part of parents.
- Fear of being judged as a failing parent.

- Past or ongoing experience of discrimination.
- Low value placed on education.
- Beliefs about keeping children at home until they are old enough to start school.

Life factors

- Work pressures and working long hours or unpredictable work patterns.
- Inflexible timing of services.
- Lack of childcare.
- Stressful lives and circumstances e.g. poverty, mental health, single parenthood, disability, illness, family transience.

Knowledge

- Lack of knowledge about brain development in the first three years
- Not understanding the difference they can make to their child's development.
- Lack of confidence and knowledge about how to be involved.
- Inappropriate expectations of children's development.
- Lack of knowledge about local services or opportunities.
- Own literacy and numeracy levels poor.
- Lack of confidence in English if it is not their first language.

Reaching and including vulnerable families

Evaluation of the ELPP and PPEL demonstration projects showed it is possible to reach and engage vulnerable parents. The projects generated important learning about the time, sensitivity and quality of relationships needed to overcome barriers to parental involvement in early home learning.

A major shift in focus for many services who participated in the ELPP and PPEL projects was to see vulnerable adults primarily as parents rather than clients and to bring them into a partnership which recognized their importance to their child's learning.

Key messages

- Allow enough time for focused and persistent outreach to ensure vulnerable families within targeted areas of need are included.
- Develop practitioner capacity and expertise in relation to outreach work.
- 'Take the service to the parent' where necessary, rather than wait for parents to come to settings. Work with parents in the home is particularly effective in reaching and engaging the most vulnerable parents.
- Provide services in flexible ways and at flexible times.
- Involving parents in early home learning activities can provide a way of reaching vulnerable parents who would not otherwise access services; the focus on helping their children learn, rather than on generic parenting skills, can lessen the feelings of inadequacy that may prevent parents seeking help.
- Services to engage the most vulnerable families in their children's early home learning cannot stand alone. They need to be part of a raft of services to address multiple needs.

(Continued on Page 10)

- A flexible approach is needed when helping vulnerable adults to engage in their child's early home learning. Practitioners need to make informed, responsive decisions about how to best support and involve the parent; other issues such as financial worries or depression may need to be addressed before, or at the same time as, helping them to support their children as learners.
- Voluntary and community organizations have particular expertise in reaching and engaging vulnerable families and have a proven track record in the kinds of responsive and innovative practices that characterize locally appropriate preventative work. ([Edwards et al., 2006](#))
- Respond quickly when parents raise a concern about their child's development. Parents who experience difficulties in accessing specialist help such as speech therapy may lose trust and confidence in services as a result.



What parents need from early years services

Recognizing parents' expertise in their own children and lives, and doing things with families rather than to them is crucial.

What works in parenting support? [Moran et al., 2004](#)

The relationship between parent and practitioner is at the heart of effective services to involve parents in their children's early learning. For a parent who lacks the confidence and trust to access services, forming a warm and positive relationship with a practitioner can be the bridge to available help and information.

Parents give consistent and clear messages about the kind of relationship and help that works for them. They want:

- to remain in control of their family lives and be treated as active participants in meeting their children's needs
- to be listened to and treated with respect
- to be helped by 'professional friends' – practitioners who are confident and well-informed, but who are able to get alongside parents and show an interest in them and their lives
- clear information and advice about their children's needs and how they can meet them
- practical guidance to build their confidence and skills in providing positive early learning experiences
- to join in activities with their child where they can meet other parents, have fun and share experiences.



Working inclusively

Families come in all shapes and sizes; a responsive approach is crucial in tailoring services to the needs of individual parents and their children and in ensuring that the most vulnerable families are included. This kind of responsive approach involves careful thinking about where and how support is offered.

Redcar and Cleveland has developed a project called Play-at-Home. It involves a series of home visits to children and families, with the aim of increasing parent confidence and involvement in their children's play and learning. The families invited to take part are identified as those who are not engaging in other opportunities offered by centers or other local services. (Continued on page 17 Families)

UTS Training Opportunities

FSCT Child Abuse 101: Indicators of Abuse and Neglect August 26, 2011 and September 27, 2011 at ProKids, Indianapolis, IN. Understand the indicators of child maltreatment, the risk factors for maltreatment, and reporting laws and responsibilities. Prevent Child Abuse Indiana presenters: Sandy Runkle, MSW and Carol Poole, MSW.

FSCT - Hey Kids, Let's Play! September 9, 2011 Indianapolis, IN (This training is FULL—Watch for future dates) From the authors of Mommy the T.V.'s Off...Now What? This training targets Service Coordinators and Developmental Therapists new to early intervention, highlighting infant and toddler development, atypical development, and activities and strategies in providing First Steps services.

FSCT – Understanding Diversity within Families TBA

Identify individual beliefs and biases related to your own culture. Determine action steps towards developing cultural sensitivity that can be integrated into your work. Recognize cultural differences and report how you value them in relation to families and have an opportunity to talk about the aspects of recognizing the importance of fathers and their roles within the family structure.

FSCT It's Online, but Can I Trust It? August 19, 2011 Marion, IN.

Who do you trust? Find out how to identify authoritative sources while developing a toolkit of go-to resources for education and health information. Christina Wray is from Center for Disability Information and Referral through the Indiana Institute on Disability and Community (IIDC)

Seminar Objectives:

1. Identify authoritative sources online.
2. Develop a toolkit of free online resources in health and education.
3. Learn how to utilize InSPIRE to access scholarly works in your subject area.

FSCT – Literacy into Therapy - TBA

All early interventionists play a vital role in the development of the infants and children we service. As providers, we not only affect a child's current development, we also have the ability to shape a child's future academic and social success. Incorporating literacy into therapy goals allows us as providers to meet the developmental needs, abilities and interests of the children we serve. This training session is an interactive look for all disciplines on why and how literacy can be incorporated into oral language, gross and fine motor and social activities.

FSCT Grief- Facilitating Acceptance

August 3, 2011 9-12:00 PM Bloomington/Location TBD

September 1, 2011 9-12:00 PM Fort Wayne/Location TBD

This three hour seminar will focus on the stages of grieving, nature of the loss, effects on the family dynamics and facilitating acceptance- a holistic model for grieving while working with families in the Early Intervention system. Lara has a unique role as a parent of a child with special needs and provider of rehabilitation services in the Early Intervention system. The seminar will include personal and situational examples of grief. Additionally, support resources will be provided to be shared with families that providers are working with directly. Lara De Poy, MSOTR is the mother to three boys, Jackson (10) with Cerebral Palsy, Owen (7) and Isaac (4). She is also the Program Director at the Jackson Center for Conductive Education and specializes in the treatment of sensory integration/sensory processing disorders, neurological and orthopedic disorders, and early intervention and developmental delay.

Upcoming Face-to-Face FSCT: AEPS Courses

August 4 & 5, 2011 – AEPS 2-Day Certification Course (Additional dates TBA)

FSCT – AEPS: An Overview (Onsite - Additional dates TBA)

Available Online First Steps Core Trainings

Need a quick course for credentialing, check out these online offerings available 24/7.

FSCT – AEPS: An Overview

FSCT – A Family-Centered Approach to Procedural Safeguards

FSCT – Direct Service Provider Refresher Course

FSCT – Providing EI Supports and Services in Everyday Routines, Activities, and Places

FSCT – Understanding and Implementing Positive Transitions for Children and Families in Early Intervention

Your Child's Development

This is a really fun time for parents, as 1-year-olds are able to explore the world in new ways and are eager to do things *all by myself!* They watch their loved ones very carefully and copy a lot of what they see. This is one of the most important ways toddlers learn how the world works.

How do you see your child learning from watching you?



What Your Toddler Can Do	What You Can Do
<p>I'm moving!</p> <ul style="list-style-type: none"> • I may walk on my own or by holding your hand. • I am learning to crawl up stairs but can't come down yet. • I can throw a ball and turn pages in books. 	<p>Give your child just enough help to reach his goal. If he wants to stand, let him hold your fingers for balance.</p> <p>Support your child as he practices new skills like climbing stairs. Children need time to work on these new skills...safely!</p> <p>Encourage your child to turn the pages when you read together.</p>
<p>I'm starting to talk and understand so much more.</p> <ul style="list-style-type: none"> • I may use some words like <i>duhduh</i> for dog. • I can show you what I want through my actions. I may bang my high chair when I want more food. • If you ask me to, I can point to a body part or a picture in a book. 	<p>Choose books about things that interest your child like animals or other children.</p> <p>Build your child's vocabulary. If she points to or says <i>bus</i>, you can say: <i>The school bus is driving down the street.</i></p> <p>Name the people, places, and things that your child sees each day: <i>That's a garbage truck taking our trash.</i></p> <p>Play games that involve following directions: <i>Throw the ball to me.</i></p>
<p>I want to do more for myself.</p> <ul style="list-style-type: none"> • I say <i>no</i> or show you in other ways that I want to do things on my own. 	<p>Involve your child in self-help tasks like washing his hands.</p> <p>Follow your child's lead. Let him choose what toys or games to play.</p>
<p>I love to imitate.</p> <ul style="list-style-type: none"> • I copy actions I've seen other people do, like stir a pot or talk on the phone. 	<p>Join in your child's play. If you see her putting a blanket on her toy bear, ask: <i>Does Teddy need a bottle before bed?</i></p> <p>Give her objects to play with that she sees in "real life," like plastic dishes, a toy telephone, a small dust broom.</p>



As you use this resource, remember that your child may develop skills faster or slower than indicated here and still be growing just fine. Talk with your child's health care provider or other trusted professional if you have questions.

Your family's cultural beliefs and values are also important factors that shape your child's development.

For more information on parenting and child development, go to: www.zerotothree.org.

What's on Your Mind

My 14-month-old is such a picky eater! Sometimes I worry that she is not eating enough to stay healthy.

Picky eating is very common at this age. Most children are feeding themselves. This means they are able to choose what to eat—or not eat. The key is to avoid turning mealtime into a power struggle. Offer your child three or four healthy food choices that she usually likes at each mealtime (like pieces of turkey and cheese, cooked peas, and some banana). Then let her decide what and how much she wants to eat. Remember, as long as your child seems to enjoy eating and has the energy to play and interact with you, she is probably doing just fine. Be sure to talk to your child's health care provider if you are concerned or have questions.

Did You Know...

The majority of parents (51%) believe that 15-month-olds are able to share? Actually, most children learn to share and take turns between the ages of 2 and 3. Even after that, they need a lot of practice and help with these important social skills.¹

What It Means for You:

Young toddlers can seem like “big kids” in many ways. They understand so much of what they hear and see that it can be easy to expect a lot from them—more than they really can do yet. At 15 months, toddlers do not yet have the self-control necessary to share and take turns. They can't stop themselves from reaching for a favorite toy, even while someone else is playing with it. This is because the part of their brains responsible for

Spotlight on Temperament

Every child is born with his own individual way of approaching the world—this is called his temperament. For example, some children are easygoing about changes. Others react very strongly to what seems like a small change, like new pajamas. Some children are very active. They love to move. Other children prefer to sit and watch the world around them. Some children enjoy new experiences and meeting new people. Others are slower to warm up in new situations. These are all examples of different temperaments.

There is no right or wrong, better or worse temperament. Temperament is not something your child chooses, and it is not something that you created. It's very important for children to be accepted for who they are. Use what you know about your child's temperament to

encourage his strengths and to support him when needed. For example, if your child has a hard time with separations, you can guess that bedtime might be challenging. You can help your child by using the same bedtime routine each night (story, milk, tooth-brushing, and lullaby).

Your temperament matters, too. You might love to meet new people and try new things but your child doesn't. Being aware of this difference is important. It helps you understand how your child's needs may be different from yours. It also helps you learn what to do in order to support and respect your child for who she is.

How would you describe your child's temperament? How do you see her temperament influencing her behavior?

self-control is still developing. But you can begin teaching your child about sharing. Explain the rule: *We are going to take turns with the jack-in-the-box. Derek is going to use it now.* Then help your child focus on another activity while his friend has a turn. Most importantly, stay calm and be patient. Sharing is a skill that comes with time, and with your support and guidance.



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**Infant/Toddler Specialists of Indiana
7th Annual Conference
September 8-9, 2011**

Ft. Harrison State Park, Indianapolis, IN

**Approved
for FSCT!**

Enhancing the Dance with Infants, Toddlers, and Their Families

Who is the ITSI Institute for?

Do you provide education, care, or supportive intervention for infants, toddlers, or families in Indiana? Do you provide leadership at the program, community, or state level? If you answered "yes," then you are an Infant Toddler Specialist and this Institute is for you!

What is ITSI?

The need for high quality child care, education, and early intervention for Indiana children, birth to three years old, has increased dramatically. Yet the preparation of professionals qualified to plan and supervise services for infants and toddlers has lagged behind. Purdue University and Indiana University are working in partnership with the State of Indiana (Family and Social Services Administration) and other organizations to promote the sharing and development of new resources for Indiana professionals who work with infants and toddlers — the Infant Toddler Specialists of Indiana (ITSI).



The goal of the ITSI initiative is to enhance existing resources and strengthen the professional identity of Infant Toddler Specialists. The initiative has created an ongoing statewide professional development network of Infant Toddler specialists — community leaders providing high quality services to infants, toddlers, and their families.

What is the ITSI Institute about?

The theme, "Enhancing the Dance with Infants, Toddlers, and Their Families," is focused on effective collaboration between the many people that are involved in the lives of Infants and Toddlers. Presenters will "dance" around the topics of strengthening key relationships, home visiting and children with special needs, and program designs and curriculum strategies that can enhance the "dance," as well as viewing international perspectives on effective child care program strategies. So find your dance partner and get ready to move and learn at the 7th Annual ITSI Institute.

Registration is online at:

https://www.eventreg.purdue.edu/ec2k/CourseListing.asp?master_id=1386&master_version=1&course_area=1267&course_number=119&course_subtitle=00. You will be required to pay by credit card. Please note that payment is due upon submission of your registration.

SAVE THE DATE

THE INSTITUTE FOR STRENGTHENING FAMILIES

SEPTEMBER 19-21, 2011

New Location - THE HILTON INDIANAPOLIS NORTH



**It is never too late
to have a happy childhood.**

Policy Reviews and Updates

The transition period for providers of OT, PT, SLP and DT to join a state approved provider agency ended on July 1, 2011. Direct providers in these disciplines must now work by direct employment/contract and under the supervision of an approved Provider Agency. This change requires a review and update to some long standing First Steps policies and procedures.

Credentialing – The Indiana First Steps System employs a credentialing process to assure the quality of personnel providing services to children and families. Credentialing is a process of accumulating points earned through academic education, work experience and continuing education through in-service training, seminars and conferences. The practice of early intervention requires specific knowledge and skills that change and develop over time and for most disciplines are not adequately covered in their pre-service training programs. Early intervention specialists and associates (with the exception of physicians, Interpreters and transportation providers) who provide direct services to children and families in their home or community settings must obtain a First Steps credential within two years of their enrollment. Once the initial credential is awarded, providers and service coordinators must re-credential annually.

The First Steps Personnel Guide (Revised December 2010) contains a detailed explanation of the credential process on pages 11-14. An electronic copy of the Personnel Guide is available at <http://www.utsprokids.org/fsnetworkapplication.asp>.

- Provider Agencies are responsible for ensuring that all employed/contracted providers meet all applicable enrollment and credentialing requirements. This includes the provision for all providers to pay the Annual Training Fee by the date due, complete one First Steps Core training and four Training Times Assessments annually, as well as any additional training to meet credential point requirements.
 - Provider Agencies are responsible for maintaining provider files with copies all required enrollment and credentialing documentation. This file must contain current license, insurance, criminal history and education/training documentation.
 - Provider Agencies are responsible for verifying the accuracy and completeness of the provider's enrollment and/or credentialing package. Prior to submission to the CRO, the Provider Agency should insure that all required information is included in the packet. A comprehensive checklist for initial and annual credentialing is included in the Personnel Guide on pages 19, 20, 22 and 23. Required documentation includes:
 - **Current Indiana professional license, if applicable**
(OT, OTA, PT, PTA, SLP, MD, RN, SW, RD)
 - **Proof of license expiration date, if applicable**
(printout from the Indiana Professional Licensing Agency website at www.ipla.in.gov)
 - **Professional liability insurance certificate**
 - **Criminal history inquiry**
 - **Current Summary of Activity grid to document the required credential points**
 - **Copy of My Trainings and My Quizzes**
(to document mandatory First Steps Core Training Requirements)
 - **Direct Service Provider Supervisor Agreement, if applicable**
(required for DTA, PTA, OTA, Speech Aide, and DT in first 12 months of enrollment)
 - **Supervisor Credential letter, if applicable**
(required for DTA, PTA, OTA, Speech Aide, and DT in first 12 months of enrollment)
4. Questions regarding enrollment and credentialing should be directed to CSC at (866) 339-9595, option 2.

(Continued on page 16)

Provider Agency Training/Education Requirements – Provider Agencies must offer its providers supervision and support. This requirement includes:

- mentoring for new and inexperienced providers.
- monitoring provider compliance with completion of Training Times and First Steps Core Training.
- providing State-directed trainings and education within a specified time frame.
- conducting semi-annual trainings related to service delivery topics.
- educating providers regarding written SPOE procedures for the respective service area.
- communicating expectations for appropriate service levels, including clear guidelines for reduction and discharge.

Provider Agency training may be counted towards credentialing when the content is related to the First Steps Core Competencies and is relevant to children, birth through five years. The competency areas are outlined in the Personnel Guidelines on pages 16-18. They include 1) Foundations of Early Intervention, 2) Infant/Toddler Typical and Atypical Development, 3) Infant/Toddler and Family Assessment, 4) Early Intervention Delivery Strategies, 5) Family Partnership and Support Strategies, and 6) Team Relationship Skills. A copy of the meeting agenda and/or training handouts must be maintained in the provider's credential file. Only actual training time may be taken. One hour equals .1 credential points. Breaks, content on agency policies, announcements, etc. may not be included.

Provider Substitution - First Steps has long recognized that there are times when a provider may be unavailable due to illness, vacation or personal emergencies. In these short (less than 2 week) planned or unplanned instances, **the provider agency may substitute a provider of the same level and discipline** when the family indicates a desire to continue the IFSP service without interruption. (Families have the option to wait for their regular provider to return.)

The substitute must provide services as outlined in the IFSP and the plan of care determined by the ongoing provider. The provider agency bills for the substitute under the established authorization. There is no need to notify the service coordinator or the ED Team for a change in authorization. Since the provider agency is responsible for all billing, the provider agency is also responsible for insuring that the substitute provider is reimbursed per their employment and/or contract agreement.

When the length of absence is anticipated to exceed 2 weeks, (i.e., maternity or family/medical leave) **the Provider Agency should contact the family to assist them in choosing a new provider of the same level and discipline**. If the provider agency is able to identify **a new provider of the same level and discipline**, the provider agency may continue to bill on the current authorization through its end date. The Provider Agency must notify the service coordinator of the change in provider. The service coordinator will obtain an authorization for the new provider with the next change page authorization.

If the provider agency cannot offer a provider of the same level and discipline, they must notify the service coordinator who will contact the family to discuss their options for changing/discontinuing the service or choosing a new provider agency that can offer **a provider of the same level and discipline**.

Co-Treatment - Indiana First Steps policy recognizes 2 types of co-treatment.

Co-treatment can occur in the place of regularly scheduled sessions, when the co-treating providers see the child/family together and each provider only bills for an equal portion of the combined session time. This type of co-treatment does not require IFSP or EDT approval, but should be justified and documented in the providers' and child's records.

For example, a child receives PT for 45 minutes weekly and DT for 60 minutes every other week. The providers, with parent consent, feel that a co-treating session would be helpful to review seating and

positioning to enhance independence during meals and play. The providers agree to meet with the child and family for a combined session of 90 minutes. They would each bill for ½ of the total session time (not to exceed their authorized time).

The issue clarification states, “At times it may be of benefit for the child to have two therapists of different disciplines working with the child during the same time period. When two or more early intervention providers work directly with a child and/or family together, they should each bill for ½ (or an equal portion if more than 2), of the total session time at their rate of reimbursement taking into consideration the differential for “off” versus “on” site service delivery.”

The second form of co-treatment allows 2 providers to treat a child/family at the same time with both providers billing their full session rate. In this case, the plan to co-treat must be written into the IFSP and approved by the ED Team prior to the first co-treating session. This type of co-treatment is a strategy to meet an IFSP outcome and must be documented as such in the IFSP and Progress Reports. The frequency and duration of the co-treatment sessions should be clearly documented. Each provider receives an authorization for their service at the frequency and duration determined by the IFSP team. A specific co-treating authorization is not issued. The need for co-treatment must be evaluated for each authorization period.

For example, a child with cerebral palsy has a feeding disorder and exhibits very high muscle tone. He receives SLP 45 minutes weekly and PT for 60 minutes weekly. The physician and IFSP team feels that the child is ready to initiate eating solid foods in a high chair, as long as positioning and tone can be controlled. An IFSP outcome is written to address the child’s feeding and tone issues and specific strategies include having the SLP and PT co-treat weekly for four sessions to develop effective feeding positions that will improve muscle tone and function. In this instance, both the SLP and the PT each would be paid for the co-treating sessions. The PT could bill for up to 60 minutes as authorized and the SLP could bill for up to 45 minutes as authorized.

The Issue Clarification states, “However, with the use of Eligibility Determination Teams (ED Team) throughout the Indiana, two early intervention therapists may work directly with the child and/or family together and each bill for the total session time at their rate of reimbursement for their specialty if this form of treatment is approved by the IFSP team members, including the ED Team. This form of co-treatment must be approved prior to the first treatment session with the child and/or family.”

(Families –continued from page 11)



The families receive weekly visits for anything between six and sixteen weeks. The approach is flexible and adapted to individual needs. Each session lasts for around one hour and usually begins with a rhyme or song, followed by a play activity and then a book or story.

Some parents feel more relaxed at home and take part in playing with their child without feeling self-conscious about playing in front of other parents and professionals. The visits help to build confidence by looking at parents' strengths – the things they do already – as well as the things they would like to change and learn more about. As the weeks go on, the balance gradually shifts and parents begin to take the lead in playing with their child with support. Parents are also gradually introduced to and encouraged to attend group-based sessions within children's centers and the local community.

Identifying Vision and Hearing Problems in Infants with Disabilities

By Deborah Chen, Ph.D.

Chen, D. (2000). Identifying vision and hearing problems in infants with disabilities. *IDA News*, 27(3), 1-3.

Vision and hearing are such primary avenues for learning that infants who have developmental delays or disabilities should receive comprehensive ophthalmological and audiological evaluations. Unfortunately, this is not common practice. Without accurate information about the status of an infant's vision or hearing, service providers cannot be confident that they are providing the most appropriate interventions to promote early development. A child's inattentiveness to certain activities or delay in speech and language development may be influenced by an unidentified vision or hearing problem, rather than solely due to an obvious motor or developmental delay. Research indicates that infants who are eligible for early intervention services are more likely to have a vision impairment or a hearing loss than infants without disabilities. Children who have developmental delays, cerebral palsy, or Down syndrome have a higher incidence of refractive errors and other ophthalmological problems than children without disabilities. About 70 percent of children with visual impairments have an additional disability. Over 75 percent of children with Down syndrome have a hearing loss, and over 35 percent of children with hearing loss have an additional disability. Further, ear infections, which can cause a fluctuating hearing loss, is a common occurrence in infancy. These statistics emphasize the need for infants with developmental delays or disabilities to receive audiological and ophthalmological evaluations and the importance of an interdisciplinary approach to early intervention services.

The purpose of this article is to provide questions that early intervention service providers can use to guide their review of medical records, their interviews with families, and their systematic observations of infants. This way, service providers may identify high risk indicators associated with visual impairment or hearing loss and refer these infants for additional evaluation, as needed.

Family Interview and Medical Records

1. Has the infant had ophthalmological and audiological evaluations?

If yes, what tests were conducted and what were the results? If the infant was identified as having a visual impairment or hearing loss, what services and inter-

ventions have been provided to address these needs? It is important to find out test results, whether any recommendations were made and acted upon, whether the family has any questions and concerns, and when a follow-up evaluation should be scheduled.

2. Does anyone in the family have a visual impairment or hearing loss?

If these problems are related to hereditary factors, the infant should receive comprehensive audiological and ophthalmological evaluations.

3. Is there any problem in the infant's prenatal or birth history that is associated with hearing loss?

These factors include prenatal exposure to certain maternal infections (e.g., toxoplasmosis, syphilis, rubella, cytomegalovirus, herpes), prematurity, hypoxia, an Apgar score of 3 or less at 5 minutes after birth, a hyperbilirubinemia level requiring transfusion, prolonged medical ventilation or prolonged use of ototoxic medication.

4. Is there any problem in the infant's prenatal or birth history that is associated with visual impairment?

These factors include prenatal exposure to certain maternal infections (e.g., toxoplasmosis, syphilis, rubella, cytomegalovirus, herpes, HIV, chicken pox), prematurity, hypoxia, and abnormal prenatal brain development (Teplin, 1995).

5. Does the infant have a diagnosis that is associated with hearing loss?

These diagnoses include head trauma, cerebral palsy, specific syndromes (e.g. CHARGE, Down, Fetal Alcohol, Goldenhar, Hurler, Norrie, Refsum, Trisomy 13, Waardenburg), certain childhood infections (e.g., bacterial meningitis, mumps, measles) and particular neurodegenerative disorders (e.g. neurofibromatosis, Tay-Sach, Niemann-Pick disease).

6. Does the infant have a diagnosis that is associated with visual impairment?

These diagnoses include head trauma; cerebral palsy; specific syndromes (e.g., CHARGE, cri du chat, Down, Fetal Alcohol, Goldenhar, Hurler, Lowe, Marfan, Norrie, Refsum, Trisomy 13, Usher); bacterial meningitis; and particular neurodegenerative disorders (e.g., neurofibromatosis, Tay Sach).

7. Does the infant have frequent ear infections, earaches, or discharge from the ears?

Middle ear infections or otitis media can cause a mild, fluctuating hearing problem that may influence the infant's ability to develop language and comprehend speech. Some infants have ear infections but show no symptoms; while others may seem tired, sick, or unresponsive to sound.

Systematic Observations

8. Are the infant's face and ears normal in appearance?

High risk signs for hearing loss include cleft lip or palate; malformations of the face, head or neck, or ears.

9. Are the infant's eyes normal in appearance?

High risk indicators of vision problems include a drooping eyelid that covers the pupil, abnormal eye shape or structure, absence of a clear dark pupil, and persistent redness in the conjunctiva that is normally white, and persistent tearing without crying.

Other indicators include jerky eye movements (nystagmus), an absence of eyes moving together, or a sustained eye turn after the infant is 4 to 6 months old.

10. How does the infant respond to different types of auditory stimuli?

Depending on the type and severity of the hearing problem, an infant may attend inconsistently to sounds, respond to some sounds and not to others, or may not respond at all. Infants with mild or moderate hearing losses may still demonstrate early listening behaviors such as *attention or alerting* to sounds, i.e., changes in facial expressions, vocalizations, or in activity and *discrimination and recognition*, i.e., responding differently to familiar and unfamiliar voices; imitating vocalizations; responding to familiar words (e.g., name, "no", songs). However, without early identification and appropriate intervention, even a mild or moderate hearing loss will have a negative effect on the infant's language development and speech comprehension, particularly when the infant has additional special needs.

11. How does the infant respond to different types of visual stimuli?

Depending on the type and degree of visual impairment, children show a preference for brightly colored or black and white objects. They may seem to pay

more attention if the objects are presented at particular distances or positions. Some children with visual impairment may be very sensitive to bright light and may squint or close their eyes. Infants with visual impairment may still show *attending or alerting behaviors* by smiling, looking, reaching, or orienting toward a preferred object or person; and *discrimination, recognition, and examining behaviors* by differentiating between familiar and unfamiliar people and objects and indicating preferences. However, without early identification and appropriate intervention, a child who has a visual impairment will have more difficulty discriminating, recognizing and understanding pictures and letters, particularly if this child has additional special needs.

12. Does the infant produce vocalizations that are typical for his or her age?

By 12 months, infants make a variety of sounds and use a few words. A hearing problem may result in limited vocalizations; abnormal voice, intonation, or articulation; or delay in speech development.

13. Does the infant have an unusual gaze or head position when looking at something or someone?

In order to see better, an infant with a visual impairment may turn his or her head in certain positions to look at an object, hold object close to eyes or move head close to the object, or seem to look beside, under, or above the object of attention.

14. Does the infant demonstrate visually guided behaviors that are typical for his or her age?

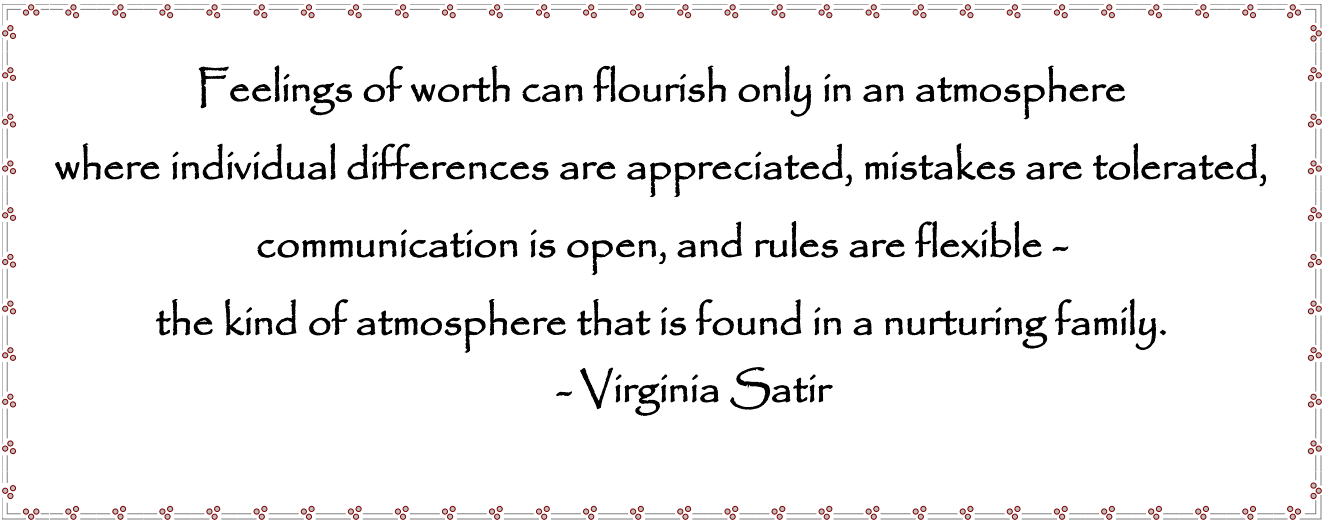
High risk indicators of visual impairment include lack of eye contact, visual fixation or following by 3 months of age and an absence of accurate reaching for objects by 6 months old.

If an infant has a medical history, diagnosis, physical appearance, or behaviors that are risk indicators of visual impairment or hearing loss, then early intervention service providers should discuss these concerns with the child's family and with relevant program staff (e.g., a nurse, speech and language therapist, and teachers certified in visual impairment or deaf and hard of hearing specializations) to determine the appropriate steps and possible interventions. To achieve the goal of promoting early development, early intervention services must ensure that infants with developmental delays or disabilities have access to comprehensible sensory information. Early identification of vision and hearing problems is a significant first step.

(Continued on page 20)

References

- Capute, A.J. & Accardo, P.J. (Eds.) (1996). *Developmental disabilities in infancy and early childhood. Vol II: The spectrum of developmental disabilities*. Baltimore: Paul. H. Brookes.
- Chen, D. (Ed.) (1999). *Essential elements in early intervention: Visual impairment and multiple disabilities*. New York: AFB Press.
- Chen, D., Friedman, C.T., & Calvello, G. (1990). *Parents and visually impaired infants*. Louisville, KY: American Printing House for the Blind.
- Ferrell, K.A. (1998). *Project PRISM: A longitudinal study of the developmental patterns of children who are visually impaired. Final Report. CFDA 84.0203C -Field -initiated Research HO23C10188*. Greeley, CO: University of Northern Colorado.
- Flexer, C. (1994). *Facilitating hearing and listening in young children*. San Diego, CA: Singular Publishing Group.
- Gatty, C.G. (1996). Early intervention and management of hearing in infants and toddlers. *Infants and Young Children*, 9(1), 1-13.
- Hayes, D., & Northern, J.L. (1996). *Infants and hearing*. San Diego, CA: Singular Publishing Group.
- Joint Committee on Infant Hearing (1994). Position statement. *Audiology Today*, 6(6), 6-9.
- Kile, J.E., Schaffmeyer, M.J., & Kuba J. (1994). From assessment to management in infant and toddlers with unusual auditory behavior. *Infant-Toddler Intervention*, 4, 299-318.
- Lueck, H.A., Chen, D., Kekelis, L. (1997). *Developmental guidelines for infants with visual impairment. A manual for early intervention*. Louisville, KY: American Printing House for the Blind.
- Northern, J.L., & Downs, M.P. (1991). *Hearing in children* (4th ed.). Baltimore, MD: Williams & Wilkins.
- Nozza, R.J. (1994). The effects of mild hearing loss on infant auditory functioning. *Infant-Toddler Intervention*, 4, 285-298.
- Roberts, J.E., Wallace, I.F., & Henderson, F.W. (1997). *Otitis media in young children. Medical, developmental, and educational considerations*. Baltimore: Paul H. Brookes.
- Sobsey, D., & Wolf-Schein, E.G. (1991). Sensory impairments. In F.P. Orelove & D. Sobsey, (Eds.). *Educating children with multiple disabilities: A transdisciplinary approach* (2nd ed.). (pp. 119-154). Baltimore, MD: Paul H. Brookes.
- Teplin, S.W. (1995). Visual impairment in infants and young children. *Infants and Young Children*, 8 (1), 18-51.
- Wesson, M.D., & Maino, D.M. (1995). Oculovisual findings in children with Down syndrome, cerebral palsy, and mental retardation without specific etiology. In D.M. Maino (Ed.), *Diagnosis and management of special populations* (pp.17-54). St. Louis, MO: Mosby Year Book.



Feelings of worth can flourish only in an atmosphere
where individual differences are appreciated, mistakes are tolerated,
communication is open, and rules are flexible -
the kind of atmosphere that is found in a nurturing family.
- Virginia Satir

Legislative Update Q & A

What is the difference between a self-funded (ERISA) and a fully funded (non-ERISA) insurance policy?

A self-funded insurance policy is one in which the sponsoring employer pays all claims, either directly or through a third party administrator/insurance company. Self-funded plans are almost always overseen by the jurisdiction of the federal government under the Employee Retirement Income Security Act (ERISA).

Many large companies have found that they can control health insurance costs better by “self” funding their own plans. The company funds the health care plan directly or through premiums paid by its employees. It often contracts with a third party administrator/insurance company to obtain negotiated discounts with hospitals, physicians and other providers and to process its claims. Once the claims have been processed, the company is responsible to pay for the claim. Sometimes a self-funded plan may also include a stop loss policy. This type of policy protects the company from paying for very large, unanticipated and catastrophic healthcare expenses.

Employees at companies with a self funded plan still will have insurance cards that often are in the name of the third party administrator/insurance company. Because the TPA/Insurance company only processes the claims and is not responsible for actually paying the claim, the self-funded plans may have the following statement on the back of the insurance card:

“X Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.”

A fully funded (non-ERISA) insurance plan is one in which the company and/or employee pays insurance premiums to an insurance company for a prescribed set of healthcare benefits. Non-ERISA plans are governed by the state. Plans sold in Indiana are governed by the Indiana State Department of Insurance. These plans are fully funded by the insurance company and the employer has no financial risk for any of its employees’ healthcare expenses. The company is only responsible for paying the cost of the insurance plan. The company can decide how much it will have its employees contribute to the plan cost. In a fully funded plan, the cost to the employee can range from nothing up to 100% of the insurance premium cost for an individual or family.

The back of the insurance card may not have any statement or it may read:

“X Insurance Company is the trade name of XYZ Insurance Companies, Inc. an independent licensee of the XXO Association.”

State employees and employees of state-funded universities are considered exempt. The legislation states that all plans for state and state funded university employees will participate in the capitation payments and those payments cannot go against annual or lifetime coverage caps.

Why is it important?

It is important because new rules regarding insurance coverage and limits for First Steps were enacted by the General Assembly. Indiana code cannot supersede federal rules, so these new rules only affect non-ERISA plans and exempt plans (state employee and state funded university employee insurance whether ERISA or non-ERISA).

Non-ERISA and exempt plans that cover early intervention services may now be billed a monthly bundled (capitation) rate for all eligible First Steps services. If the child’s non-ERISA or exempt insurance plan covers any eligible First Steps service, the insurance provider is to pay the monthly capitation rate and these capitation payments cannot go against the child’s annual or lifetime cap on coverage. There is no family co-payment due for any month in which a child’s non-ERISA or exempt plan paid the monthly capitation rate. If the non-ERISA or exempt plan denies payment of the capitation rate, the family must pay their monthly co-payment and they should file an appeal with their insurance company. If their appeal is successful, a credit for that co-payment is made to their account.

What happens to families with an ERISA insurance policy?

Very little will change for those with an ERISA policy. The CRO will continue to bill the health insurance plans for the units of First Steps services received, with the exception of Developmental Therapy. (DT is never billed to insurance and is billed to the family at their co-payment rate). If the child’s insurance pays the claim, then the family is not charged a co-payment for that service. Families receive a full accounting of all services billed and all third party payments received for the statement month. If the insurance company rejects or denies the claim, the family will be charged a co-payment (Continued on Page 22)

based on the number of units received for each co-pay eligible service. If the insurance claim is denied, the family should file an appeal with their insurance company and must pay the monthly co-pay. If their appeal is successful, a credit for that co-pay is made to their account. In an ERISA plan all insurance payments for First Steps services will likely apply to the child's annual and lifetime caps.

What if the child has two or more health insurance plans?

When both parents carry insurance on the child or when the child has a policy in addition to the parent's coverage, one policy is deemed primary and the other secondary. Service Coordinators must obtain information on all plans, and document each policy on a separate "Private Medical Insurance Supplement" form, noting which is primary and if the plans are ERISA, non-ERISA or exempt.

Will this new legislation change the way providers/provider agencies bill First Steps?

No, providers/provider agencies will continue to bill First Steps through PAM using the most appropriate ICD9 and CPT codes for the services they have provided. Providers/provider agencies are asked to make sure that they are using valid ICD9 codes. Denials have been received for providers dropping the

last digit from an ICD9 code (i.e., 765.1 was used and should have been 765.10). You must use all 5 digits when they are available/appropriate. Please use the ICD9 code search function.

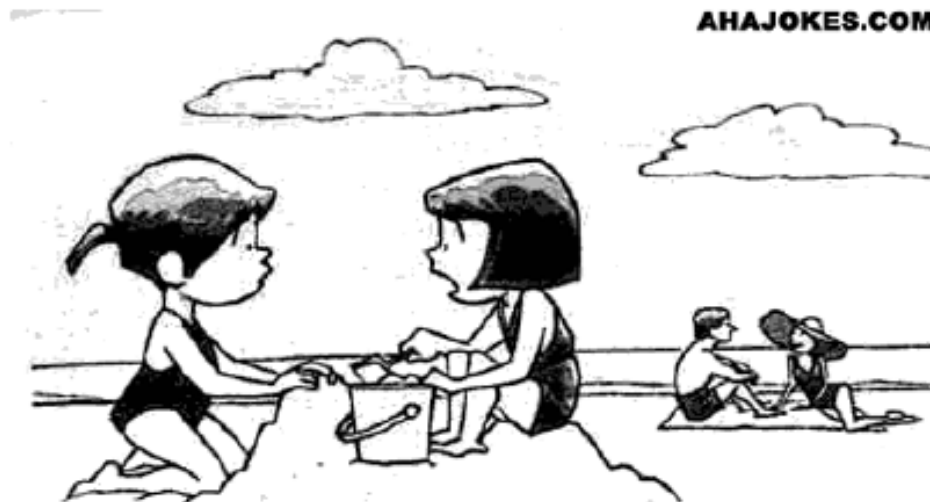
Why are co-payments now billed by units instead of sessions?

The Indiana General Assembly made the change to allow families to have more control over their co-payment costs. Traditionally, almost all First Steps sessions were 60 minutes. When families have input into the session length, it allows them some control over their co-payment rate. All family co-payments have been recalculated into units of services (15 minute increments).

Are there other changes that affect family co-payments?

Yes, the maximum monthly co-payments have all increased significantly. You can view the changes to First Steps income and co-payments at:

http://www.in.gov/fssa/files/First_Steps_Cost_Participation_Sliding_fee_Schedule.pdf



"I'm never having kids. I hear they take nine months to download."

Topic	Issue	Article Title
Adaptations in Community Settings	March-05	Sharing Information about Adaptations with Child Care and Pre-School Providers
Adaptations in Community	May-08	Integrating Therapy into the Classroom
Adaptations in Community	May-08	Suggestions for Services Provided in Child Care Centers
AEPS	December-06	AEPS Chosen for First Steps Eligibility Determination
AEPS	December-06	Assessment, Evaluation and Programming System - AEPS ®
AEPS	December-06	Frequently Asked Questions About The AEPS®
AEPS	June-06	The AEPS
Apraxia	August-09	Childhood Apraxia of Speech
Assessment	December-06	Assessment, Evaluation and Programming System - AEPS ®
Assessment	February-08	DEC Promoting Positive Outcomes for Children with Disabilities
Assessment	June-06	New Visions: A Parent Guide to Understanding Developmental As-
Assessment	June-06	The AEPS
Auditory Processing	February-09	Auditory Processing Disorders in Children
Autism	November-10	Early Intervention for Toddlers with Autism
Autism	September-06	Good Night, Sleep Tight and Don't Let the Bed Bugs Bite: Establish-
Autism	September-06	Increasing Incidence of Autism Spectrum Disorders Continues in
Autism	September-06	Mealtime and Children on the Autism Spectrum: Beyond Picky,
Autism	February-11	NIH News Toddlers with Autism Show Improved Social Skills
Autism	September-06	Opportunity to Communicate: A Crucial Aspect of Fostering Commu-
Autism	September-06	What Are Autism Spectrum Disorders?
Behavior	August-10	10 Ways to Tame Your Kid's Tantrums
Behavior	August-10	Cognitive and Verbal Skills Needed for Toilet Training
Behavior	February-11	Reading Your Child's Cues from Birth to Age 2
Behavior	August-10	Responding to Your Child's Bite
Behavior	August-10	Toileting Problems with Developmentally Delayed Children
Billing	August-07	Issue Clarification - Updated Family Signature on Billing Documenta-
Billing	February-06	More CRO Information
Billing	February-08	Payback Amounts and Justifications
Billing	March-07	Provider Update Newsletter Volume 1 Issue 2 February 2007
Billing	June-05	Transition - Issue Clarification 503-11-044
Biting	August-10	Responding to Your Child's Bite
Care for Caregiver	February-06	New Year's Resolution #1 - Take Care of Yourself
Cerebral Palsy	November-09	Cerebral Palsy: Hope Through Research
Change	February-06	Change in the Workplace
Child Abuse	May-09	Child Abuse Laws in Indiana
Child Care Settings	March-05	Sharing Information about Adaptations with Child Care and Pre-
Child Development	August-11	Your Child's Development 12-15 months
Child Development	August-10	Your Child's Development 15-18 Months
Child Development	November-10	Your Child's Development 18-24 Months

Topic	Issue	Article Title
Child Development	February-11	Your Child's Development 24-30 Months
Child Development	May-11	Your Child's Development 30-36 Months
Child Outcomes	February-08	DEC Promoting Positive Outcomes for Children with Disabilities
Child Outcomes	February-08	DEC Promoting Positive Outcomes for Children with Disabilities
Child Outcomes	September-05	Family and Child Outcomes for Early Intervention and Early Child-
Cost Participation	June-06	Cost Participation Q & A
Co-Treatment	August-11	Policy Update: Co-Treatment
Credentialing	August-09	Credentialing FAQ's
Credentialing	November-07	First Steps Credentialing
Credentialing	August-11	Policy Updates: Credentialing
Culture, Diversity	December-04	Understanding and Negotiating Cultural Differences Concerning De-
Developmental Therapy	December-06	Developmental Therapy White Paper
Developmental Therapy	May-08	Integrating Therapy into the Classroom
Documentation	May-11	Third Party Documentation for Therapies
Down Syndrome	March-07	The Goal and Opportunity of Physical therapy for Children with Down
Early Intervention Services	February-06	A Model By Any Other Name...
Early Intervention Services	September-05	A Relationship-Based Approach to Early Intervention
Early Intervention Services	September-05	A Relationship-Based Approach to Early Intervention
Early Intervention Services	November-09	Cerebral Palsy: Hope Through Research
Early Intervention Services	May-07	Cortical Visual Impairment: An Overview of Current Knowledge
Early Intervention Services	February-08	DEC Promoting Positive Outcomes for Children with Disabilities
Early Intervention Services	November-10	Early Intervention for Toddlers with Autism
Early Intervention Services	February-11	Early Literacy
Early Intervention Services	June-05	From Early Intervention to Special Education
Early Intervention Services	November-10	High Intensity Services Prior Approval
Early Intervention Services	May-08	Integrating Therapy into the Classroom
Early Intervention Services	May-10	Make the Most of Playtime
Early Intervention Services	March-05	Maximizing Your Role in Early Intervention
Early Intervention Services	August-08	Osteogenesis Imperfecta (Brittle Bone Disease)
Early Intervention Services	September-05	Principles and Strategies for Family-Centered Home-Based Services
Early Intervention Services	May-10	Promoting the Social Competence of Young Children with Disabilities
Early Intervention Services	June-05	Sensory Integration: A Key Component of the Evaluation and Treat-
Early Intervention Services	June-06	ment of Young Children with Severe Difficulties in Relating and Com-
Early Intervention Services	May-07	The Art and Science of Home Visits
Early Intervention Services	May-07	The Goal and Opportunity of Physical therapy for Children with Down
Early Intervention Services	May-11	The Importance of Early Intervention for Infants and Toddlers with
Early Intervention Services	February-10	Translating Motor Control Theory into Functional Application in Early
Early Intervention Services	December-04	Understanding and Negotiating Cultural Differences Concerning De-
Early Intervention Services	December-04	Yes, You Can! Providing Inclusive Services During Everyday Rou-
Eligibility/Need for Service	August-08	Bulletin# 06262008 - Need For Service
Eligibility/Need for Service	May-08	Issue Clarification - DRAFT Need for Service

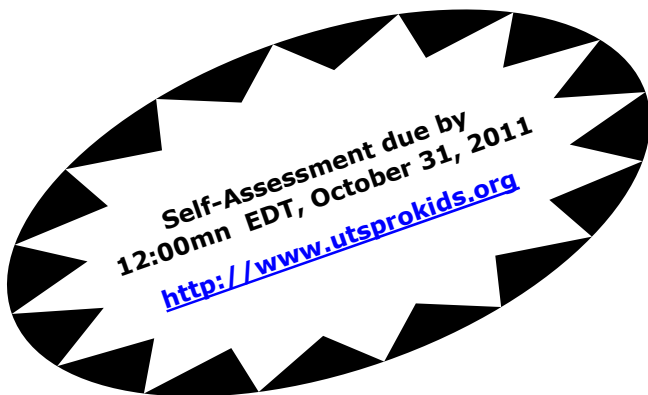
Topic	Issue	Article Title
Eligibility/Need for Service	June-06	New Visions: A Parent Guide to Understanding Developmental Assessment
Eligibility/Need for Service	December-06	State Provider Update November 2006 Volume 1 Issue 1
Face-To-Face Forms	November-07	CDC Fact Sheet on Influenza
Face-To-Face Forms	August-10	Face-To-Face Form Reminders
Face-To-Face Forms	December-06	Face-To-Face Summary Sheet
Face-To-Face Forms	December-06	State Provider Update November 2006 Volume 1 Issue 1
Family Outcomes	September-05	Family and Child Outcomes for Early Intervention and Early Childhood Special Education
Family-Centered Care	February-08	DEC Promoting Positive Outcomes for Children with Disabilities
Family-Centered Care	August-11	Early Home Learning Matters
Family-Centered Care	February-06	Early Intervention Affects Families' Quality of Life
Family-Centered Care	May-11	Father's Care - Involvement, Influence and Affection
Family-Centered Care	May-07	Generating Relevant IFSP Outcomes
Family-Centered Care	August-08	Giving Families A Chance To Talk
Family-Centered Care	March-05	Maximizing Your Role in Early Intervention
Family-Centered Care	March-05	Maximizing Your Role in Early Intervention
Family-Centered Care	June-06	New Visions: A Parent Guide to Understanding Developmental Assessment
Family-Centered Care	September-05	Principles and Strategies for Family-Centered Home-Based Services
Family-Centered Care	December-04	Understanding and Negotiating Cultural Differences Concerning Developmental Competencies: The Six Raison Solution
Family-Centered Care	May-07	Writing Functional, Meaningful and Family-Centered Outcomes
First Steps System	November-10	DDRS Moves Forward on Proposals to Reduce Expenditures
First Steps System	March-05	Maximizing Your Role in Early Intervention
Hearing	November-07	Effects of Hearing Loss on Children
Hearing	August-11	Identifying Vision and Hearing Problems in Infants with Disabilities
Home Visiting	September-05	Principles and Strategies for Family-Centered Home-Based Services
Home Visiting	March-05	Safety Tips For Home Visitors
Home Visiting	June-06	The Art and Science of Home Visits
IFSP Authorizations	February-11	3 Month Authorization Schedule and Process
IFSP Authorizations	November-10	Revised Procedures - 3 Month Authorizations
IFSP Changes	August-09	An Overview of the Process for Changes to the IFSP
IFSP Changes	December-06	Request For Change or Addition in Services ED Team Response Form
IFSP Outcomes	May-07	Generating Relevant IFSP Outcomes
IFSP Outcomes	November-09	IFSP and Transition Outcomes
IFSP Outcomes	May-08	Steps to Using the AEPS to Write IFSP Outcomes
IFSP Outcomes	May-07	Writing Functional, Meaningful and Family-Centered Outcomes
IFSP Services	March-07	Provider Update Newsletter Volume 1 Issue 2 February 2007
Infant Toddler Mental Health	November-10	Indiana Association for Infant Toddler Mental Health
Infectious Diseases	November-07	Alphabet Soup of Bacteria and Viruses
Infectious Diseases	November-07	CDC Fact Sheet on Influenza
Infectious Diseases	November-09	Home Visitor Guidelines During the H1N1 Pandemic
Infectious Diseases	November-07	Universal Precautions and Other Means of Preventing Infection
Motor Development	August-07	A Look at Motor Development in Children
National Provider Identifier (NPI)	May-07	National Provider Identifier (NPI)

Topic	Issue	Article Title
Natural Environments	May-10	Integrating Early Intervention Supports in Libraries: Baltimore County,
Natural Environments	May-08	Integrating Therapy into the Classroom
Natural Environments	March-05	Maximizing Your Role in Early Intervention
Natural Environments	March-05	Sharing Information about Adaptations with Child Care and Pre-
Natural Environments	May-08	Suggestions for Services Provided in Child Care Centers
Natural Environments	December-04	Yes, You Can! Providing Inclusive Services During Everyday Rou-
Obesity - Childhood	February-06	Childhood Obesity - What All Professionals Should Know
Occupational Therapy	May-08	Integrating Therapy into the Classroom
Occupational Therapy	August-10	Letter to Editor Re: Motor Control Theory
Occupational Therapy	February-10	Translating Motor Control Theory into Functional Application in Early
Ontogenesis Imperfect	August-08	Ontogenesis Imperfect (Brittle Bone Disease)
Physical Therapy	May-08	Integrating Therapy into the Classroom
Physical Therapy	March-05	Maximizing Your Role in Early Intervention
Physical Therapy	March-07	The Goal and Opportunity of Physical therapy for Children with Down
Picky Eater	September-06	Mealtime and Children on the Autism Spectrum: Beyond Picky,
Play	May-10	Make the Most of Playtime
Play	May-11	Public Playground Safety Checklist
Prior Approval	November-10	High Intensity Services: Prior Approval Request Form
Procedural Safeguards	May-10	General Reciprocal Consent to Release & Share Information
Procedural Safeguards	March-07	Privacy and Confidentiality
Procedural Safeguards	March-07	Privacy and Confidentiality
Procedural Safeguards	March-07	Privacy and Confidentiality
Safety	May-11	Public Playground Safety Checklist
Safety	March-05	Safety Tips For Home Visitors
Safety	February-09	Winter Driving Tips
Sensory Integration	June-05	Sensory Integration: A Key Component of the Evaluation and Treat- ment of Young Children with Severe Difficulties in Relating and Com-
Service Coordination, Role	November-08	An Overview of the Roles & Responsibilities of Service Coordination
Service Delivery Models	February-06	A Model By Any Other Name...
Service Delivery Models	March-05	Maximizing Your Role in Early Intervention
Service Delivery Models	December-04	Yes, You Can! Providing Inclusive Services During Everyday Rou-
Sleep	September-06	Good Night, Sleep Tight and Don't Let the Bed Bugs Bite: Establish-
Social Emotional	May-10	Promoting the Social Competence of Young Children with Disabilities
Speech & Language	August-09	Childhood Apraxia of Speech
Speech & Language	November-07	Effects of Hearing Loss on Children
Speech & Language	May-08	Integrating Therapy into the Classroom
Speech & Language	November-09	Letter to Editor Re: Childhood Apraxia of Speech
Speech & Language	September-06	Opportunity to Communicate: A Crucial Aspect of Fostering Commu-
Speech & Language	May-09	Speech and Language Myth busters for Internationally Adopted Chil-

Topic	Issue	Article Title
SPP/APR	September-05	Family and Child Outcomes for Early Intervention and Early Child-
SPP/APR	September-05	Family and Child Outcomes for Early Intervention and Early Child-
SPP/APR	February-06	Indiana's Part C State Performance Plan
SPP/APR	February-06	Indiana's Part C State Performance Plan
SPP/APR	November-08	Indiana's State Performance Plan and You; Understanding IDEA,
SPP/APR	March-07	Quality Review Snapshots
Substitution	August-11	Policy Updates - Provider Substitution
Tantrums	August-10	10 Ways to Tame Your Kid's Tantrums
Team Approach	May-11	Effective Team Functioning
Team Approach	March-05	Maximizing Your Role in Early Intervention
Team Approach	February-09	Working Together to Strengthen Early Intervention Teams
Third Party Reimbursement	May-11	Key Considerations for Successful Third Party Reimbursement
Toilet Training	August-10	Cognitive and Verbal Skills Needed for Toilet Training
Toilet Training	August-10	Toileting Problems with Developmentally Delayed Children
Training	August-10	A Guide to the UTS Online Trainings
Training	February-08	Additional UTS Training Information
Training	November-10	Annual Training Fee
Training	November-10	Annual Training Fee
Training	February-08	Bulletin #04-904-040-A Credentialing Requirements
Training	August-11	Provider Agency Training
Transition	June-05	FAQs About Transition
Transition	September-05	First Steps Updates and Information-Part B participation at Transition
Transition	June-05	From Early Intervention to Special Education
Transition	June-05	From Early Intervention to Special Education
Transition	June-05	Transition - Issue Clarification 503-11-044
Vision	May-07	Cortical Visual Impairment: An Overview of Current Knowledge
Vision	August-11	Identifying Vision and Hearing Problems in Infants with Disabilities



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- Have you read a great journal article that would be of interest to First Steps Providers?
- Would you like to write a Training Times article?

UTS pays trainer stipends, article reprint fees and authors of original articles for the Training Times.

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